



## Accreditation Award of Distinction

### Application for On-site Accreditation Survey (if applying for more than one clinical site, please fill out separate applications for each site)

Name of Urgent Care Center: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_ (main number)

Fax \_\_\_\_\_ (main number)

Website \_\_\_\_\_ (if applicable)

Contact Person #1: \_\_\_\_\_

Contact email: \_\_\_\_\_

Name of company owning site: \_\_\_\_\_  
(if different from above)

Address \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

Fax \_\_\_\_\_

Contact Person #2: \_\_\_\_\_  
(if different from above)

Contact email \_\_\_\_\_

For all Accreditation correspondence, whom should we contact?

Contact #1       Contact #2       Other \_\_\_\_\_

**Application (cont.)**

Approximate number of clinical visits to site during past 12 months: \_\_\_\_\_

Total number of physicians who work on-site: \_\_\_\_\_

Board certified: \_\_\_\_\_

Board eligible: \_\_\_\_\_

Number of physician extenders who work on-site: \_\_\_\_\_  
(i.e., nurse practitioners, physician assistants)

Number of support staff who work on-site: \_\_\_\_\_  
(i.e., office nurses, nursing assistants, technicians, receptionists, clerical staff)

Normal hours of clinical operation:

Monday \_\_\_\_\_ Saturday \_\_\_\_\_

Tuesday \_\_\_\_\_ Sunday \_\_\_\_\_

Wednesday \_\_\_\_\_

Thursday \_\_\_\_\_

Friday \_\_\_\_\_

Is there a board certified physician present during all open hours? \_\_\_\_\_

If not, is there a board eligible physician present during any open hours when a board certified physician is not present? \_\_\_\_\_

Are there open hours when no board certified/eligible physician is present? \_\_\_\_\_

If yes, is there a nurse practitioner or physician assistant present during those ours? \_\_\_\_\_

**Application (cont.)**

Are walk-in patients accepted during all open hours?  Yes  No

Is there a procedure to provide emergency triage for all patients and to refer them to an appropriate level of care if necessary?  Yes  No

Are there any dates during the next 90 days (from date of application submission) that you would prefer not to be surveyed? If yes, please list below:

\_\_\_\_\_

\_\_\_\_\_

On behalf of the organization hereby applying for on-site survey, I certify that all information submitted is complete and accurate as of the date below. I will notify UCAOA if there are any changes to this information. I understand that all Accreditation application fees are due at least 30 days prior to our on-site survey, and that all fees should be paid to the Urgent Care Association of America. I also understand that the \$1500 application deposit accompanying this application will be applied toward those survey fees, unless I later decline to be surveyed within 90 days of the acceptance of this application. In that instance, I understand that \$1000 of the application deposit will be refunded to the paying organization by the Urgent Care Association of America.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Title: \_\_\_\_\_

**Fax to:** 630-836-8010 or

**Mail to:** UCAOA, 4320 Winfield Road, Suite 200, Warrenville, IL

**Questions:** 877-698-2262

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For office use only:

Date application received: \_\_\_\_\_

Date application accepted: \_\_\_\_\_

Date of on-site survey: \_\_\_\_\_